Citation


| 58.28(3)e, f | 481-58.28(135C) Safety. The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III) <br> 58.28(3) Resident safety. <br> e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III) <br> f. Residents shall be protected against physical or environmental hazards to themselves. (I, II, III) <br> DESCRIPTION: <br> Based on observations, record review and staff interviews, the facility failed to adequately supervise a resident at high risk for elopement. The resident exited the facility without staff knowledge, which resulted in an immediate jeopardy to the health and safety for 1 of 4 at risk residents reviewed (Resident \#8). The facility reported a census of 39 residents. <br> Findings included: <br> A Minimum Data Set (MDS), dated 12/5/19, revealed Resident \#8 admitted to the facility on $2 / 27 / 19$. The MDS identified Resident \#8 as independent with transfers and ambulation. The resident did not use an assistive device (walker or | I | \$8,750 (Held in suspension) | UPON RECEIPT |
| :---: | :---: | :---: | :---: | :---: |

Citation



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Citation

| Citation Number: \#8029 |  | Date: <br> March 31, 2020 |  |  |
| :---: | :---: | :---: | :---: | :---: |
| Facility Nam Thomas Re |  | Survey Dates: <br> March 9-18, 2020 |  |  |
| Facility Address/City/State/Zip <br> 217 Main Street <br> Coon Rapids, IA 50058 | SB |  |  |  |
| Rule or Code Section | Nature of Violation | Class | Fine Amount | Correction date |



Citation



Citation


|  | 12/21/19 at 9:57 p.m., revealed the resident wandered and attempted to exit without success. <br> 12/22/19 at 5:48 p.m., revealed the resident wandered and attempted to exit seek without success. <br> An accident/Incident report dated 12/22/19 at 6:45 p.m. completed by Staff Q revealed Staff I (off duty registered nurse) observed the resident in the facility parking lot by the dumpsters while in her car leaving the facility. Staff I pulled back in and got out of her car and brought the resident back into the building. Wanderguard alarm sounding. <br> Review of Resident \#8's medical record showed nothing documented regarding the elopement. Resident progress notes did not contain an entry regarding the incident and the record failed to identify staff assessed the resident for injuries or that staff notified the resident's physician or family member. <br> On 3/11/2020 at 9:54 a.m., Staff I Registered Nurse (RN) reported she completed her 6 a.m. to 6 p.m. shift on 12/22/19 and punched out at 6:45 p.m. to go home. She left through the north door and walked across the parking lot to her car. Staff I stated she sat in her car for just a few |  |  |  |
| :---: | :---: | :---: | :---: | :---: |

Citation



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Citation



Citation


|  | facility was clear and walked to the nurse station area to try to assist the other staff with figuring out how to silence the alarm since they stood looking at the panel. Shortly after this, Staff I returned into the building with the resident and said the resident was outside. Staff I told us how we needed to check and make sure where the residents were. <br> Staff M's CNA statement revealed she worked the evening of 12/22/20 when Resident \#8 left the building. Staff $M$ identified self as in the dining room assisting a resident when she heard an alarm sound. Staff M stated she went to the living room door (South door) and then went to the north door and announced on the walkietalkie to all staff that the doors were clear. Staff M then went back to the alarms panel and Staff I informed her Resident \#8 got out of the facility unattended. <br> Staff R's Licensed Practical Nurse (LPN) statement dated $3 / 11 / 20$, revealed she worked on 12/22/20 and clocked out and left the facility at 6:15 p.m. Staff R was not present when Resident \#8 had left the building unattended. <br> On 3/11/20 at 2:08 p.m., Staff Q LPN (agency nurse) stated she worked the evening of 12/22/19 when the resident left the facility. Staff Q stated |  |  |  |
| :---: | :---: | :---: | :---: | :---: |

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|  | 100 feet to the side street. The facility generator <br> is also located to the left side next to the driveway <br> area. The posted speed limit is 25 mph. The <br> facility is surrounded on 3 sides by streets and <br> sits on 1 city block. The other $1 / 2$ of the building is <br> the attached clinic and the assisted living. <br> An undated facility policy titled Elopement Policy <br> revealed the facility strived to prevent elopement <br> of resident's from the facility. The policy defined <br> elopement as when a resident exits the facility <br> undetected and assessed as unsafe to leave the <br> facility unattended. Steps included: <br> a. The facility would assess all residents for <br> elopement risk upon admission and quarterly <br> thereafter to determine if they are at risk for <br> elopement. <br> b. The facility would place a wander-guard <br> bracelet (a signaling device that a resident has <br> left the building) on residents determined at risk <br> for elopement. <br> c. Charge nurses are responsible to see that the <br> wander-guard is placed on the resident initially <br> and will document each shift that the bracelet is in <br> place. <br> d. The maintenance department checks and <br> documents daily that all facility door alarms, <br> wander-guard door alarms, and bracelet function <br> of residents function correctly. They will report |
| :--- | :--- | :--- |
| 13 |  |

Citation

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| Rule or Code Section | Nature of Violation | Class | Fine Amount | Correction date |



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Iowa Department of Inspections and Appeals Health Facilities Division

Citation

| Citation Number: \#8029 |  | Date: <br> March 31, 2020 |  |  |
| :---: | :---: | :---: | :---: | :---: |
| Facility Name: <br> Thomas Rest Haven |  | Survey Dates: <br> March 9-18, 2020 |  |  |
| Facility Address/City/State/Zip <br> 217 Main Street <br> Coon Rapids, IA 50058 | SB |  |  |  |
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|  | Staff I accompanied the resident throughout the <br> entire incident. <br> FACILITY RESPONSE: |  |  |  |
| :--- | :--- | :--- | :--- | :--- | :--- |

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Facility Administrator
Date
If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty-five percent (35\%) pursuant to lowa Code section 135C.43A (2013).

Citation


| 50.7(4) | 481-50.7(10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available; <br> 50.7(4) When a resident elopes from a facility. For the purposes of this subrule, "elopes" means when a resident who has impaired decisionmaking ability leaves the facility without the knowledge or authorization of staff. <br> DESCRIPTION: <br> Based on clinical record review, staff interviews, and facility policy review, the facility failed to report an incident of elopement to the State agency. A cognitively impaired resident left the facility without staff knowledge for 1 of 4 residents reviewed at risk for elopement at the facility (Resident \#8). The facility reported a census of 39 residents. <br> Findings included: <br> A Minimum Data Set (MDS), dated 12/5/19, revealed Resident \#8 admitted to the facility on $2 / 27 / 19$. The MDS identified Resident \#8 as independent with transfers and ambulation. The | II | $\$ 500$ <br> (Held In <br> Suspension) | Upon receipt |
| :---: | :---: | :---: | :---: | :---: |

Citation



Citation

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|  | back into the building. Wanderguard alarm <br> sounding. <br> Review of Resident \#8's medical record showed <br> nothing documented regarding the elopement. <br> Resident progress notes did not contain an entry <br> regarding the incident and the record failed to <br> identify staff assessed the resident for injuries or <br> that staff notified the resident's physician, family <br> member or the State agency. |  |  |
| :--- | :--- | :--- | :--- | :--- |
|  | The facility provided a list of abuse and incidents <br> they reported to the State agency. The list did not <br> contain Resident \#8's 12/22/19 elopement. |  |  |
| An undated facility policy titled Elopement Policy <br> revealed the facility strived to prevent elopement <br> of resident's from the facility. The policy defined <br> elopement as when a resident exited the facility <br> undetected and assessed as unsafe to leave the <br> facility unattended. The policy did not direct staff <br> to notify the State agency of an elopement. |  |  |  |
| During an interview with the Administrator on <br> 3/18/20 at 9:50 a.m, he reported he discussed the <br> elopement with the former DON and she informed <br> him Resident \#8 exited the facility and Staff I <br> accompanied the resident throughout the entire <br> incident. The Administrator stated in hind-sight, if <br> he knew the full details of the incident, he would |  |  |  |

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Iowa Department of Inspections and Appeals Health Facilities Division

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|  | have reported it to the State agency as required, <br> instead of taking the former DON's word for it. |  |  |
| :--- | :--- | :--- | :--- | :--- |
| FACILITY RESPONSE: |  |  |  |

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Facility Administrator
Date
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